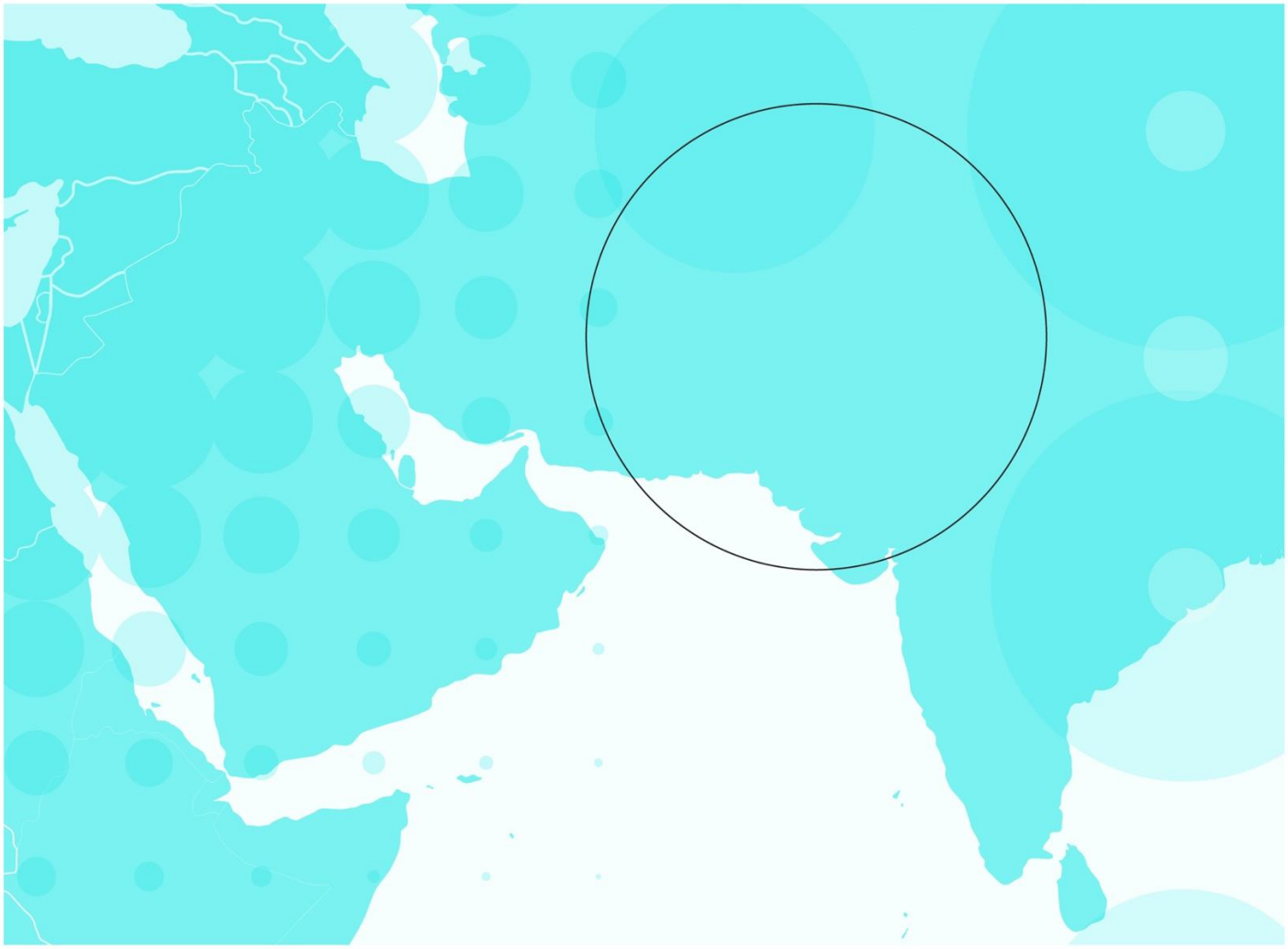

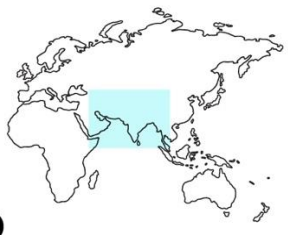

Audit Report

Global Fund Grants to the

Islamic Republic of Pakistan

GF-OIG-25-008
10 June 2025
Geneva, Switzerland

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1. Executive Summary

1.1 Opinion

Pakistan has a large TB burden, and a growing HIV and Malaria burden. Classified as a Challenging Operating Environment,[1] the country has been under the Global Fund's Additional Safeguard Policy[2] since 2020. Widespread political unrest over the last two years has impacted economic development.

Despite the challenging context, progress has been made in fighting the three diseases. TB case notifications have significantly increased, although there is still suboptimal quality of TB diagnosis. There is also a high TB treatment success rate. HIV key population services have continued, despite widespread stigma and discrimination. After large-scale flooding in 2022 generated a five-fold increase in malaria cases, the Global Fund provided US$30m in emergency funding, enabling malaria testing and treatment for affected populations.

However, poor prioritization, grant implementation delays, and limited progress in addressing perennial issues in supply chain, procurement and co-financing, have contributed to continual increases in HIV new infections (up 64% since 2018), and AIDS-related deaths (up 400% since 2010). They have also hindered impact on TB. Despite TB investments totaling US$165m in Grant Cycle 6 (GC6), TB diagnostic quality remains poor: 50% of overall notifications were clinically diagnosed rather than bacteriological confirmed. The gap between those diagnosed with drug-resistant TB (DR-TB) and those registered for treatment was 22% in 2023 and is growing, and there is a high level (69%) of DR-TB missing cases. This has contributed to high TB incidence levels: 277 per 100,000 people as of 2023, the highest rate since 2010.

The main reason for the slow programmatic progress is sub-optimal governance. There is limited national strategic direction and ownership, weak domestic financing for the three diseases, and frequent changes in senior ministry leadership. In addition, there has been poor oversight over the program management unit managing government grants for TB and malaria, as well as gaps in its capacity. While the Global Fund Secretariat attempted several initiatives to address governance and capacity issues, limited progress was made, and opportunities were missed to improve grant implementation arrangements. As a result, the adequacy and effectiveness of grant governance, implementation arrangements and risk management are **ineffective.**

Procurement and supply chain management-related costs constitute 59% of Grant Cycle 6 budgets. Most of this investment is effectively procured through international procurement channels, and first-line TB and HIV treatment commodities have been continuously available. However, a number of protracted local procurements (averaging 668 days), custom clearance delays, and weaknesses in key supply chain systems, distribution and warehousing, have resulted in stock-outs and expiries, limited product traceability, the risk of poor quality of commodities, and overall poor value for money. Stock-outs of HIV test kits were noted at 64% of visited sites. Protracted local procurements worth US$4.3m negatively impacted program delivery of key TB and Malaria activities, while traceability gaps resulted in a potential loss of 369,000 bed nets valued at US$0.9m.[3] The adequacy and effectiveness of procurement and supply chain processes and systems **need significant improvement.**

[1] COEs are countries or regions characterized by weak governance, poor access to health services, and manmade or natural crises.
[2] The Additional Safeguard Policy is a strategic risk management tool which aims to support the implementation of grants funded by the Global Fund.
[3] The potential LLIN loss was reported to the Global Fund Secretariat and the OIG audit unit by the Common Management Unit. A referral has been made to the OIG Investigations Unit.

All Principal Recipients reviewed by the OIG have robust financial controls, with no material unsupported expenditures identified for three sampled implementers. However, there were isolated instances of noncompliance with local procurement processes for material procurements. Non-adherence to proper recruitment practices for a significant number of hires in Grant Cycle 6 limits the efficiency and effectiveness of staffing investments. As such, the adequacy and effectiveness of financial management controls relating to key cost categories are **partially effective**.

1.2 Key Achievements and Good Practices

Positive response to malaria surge following large-scale flooding

In response to large-scale flooding in 2022 and a five-fold increase in malaria cases, from 0.5m in 2021 to 2.7m in 2022, the Global Fund provided US$30m in emergency funding to support continual access to medicines and health services. This supported treatment commodities, malaria prevention, as well as the rehabilitation of health facilities. It also ensured malaria testing and treatment could scale up, and that almost all confirmed malaria cases received treatment (treatment rate >98%).

Progress made in TB notification levels and treatment since the last OIG audit in 2020, and efforts to progress HIV activities

There has been an increase in TB cases notified, although issues exist with the quality of diagnosis. 1.2 million TB cases were notified from 2021 to 2023, nearing the TB national strategic plan target of 1.3 million. In 2023, the treatment success rate for drug-sensitive TB patients reached 95%. Efforts have been made to advance key population interventions, such as the launch of Opioid Substitutional Therapy (OST) services, which had been significantly delayed since Grant Cycle (GC) 5. Progress has been made in developing OST guidelines and operating procedures, obtaining drug regulatory approval, and setting up pilot sites. The number of key population-supported sites has increased considerably, from 16 to 53 during GC6.

Stronger financial controls since the last OIG audit, with no material unsupported expenditures identified

Following increased instances of fraud from 2018, the Global Fund undertook several assessments of the financial control environment and increased its operational engagement. Since the last OIG audit, the Global Fund Secretariat has strengthened financial oversight for grant activities. Electronic financial management systems and approved finance and accounting manuals are in place for all Principal Recipients (PRs), and OIG review of sample transactions across several PRs found no material unsupported expenses.

1.3 Key Issues and Risks

Persistent strategic and operational challenges hinder grants implementation

Weak capacity of the Common Management Unit (CMU), which manages government grants along with the national programs, was noted. This stems from persistent governance and implementation challenges, such as sub-optimal national strategic direction and ownership, and frequent changes in senior ministry leadership. As a result, key activities were delayed or not completed in GC6, and significant issues in local procurement, supply chain, and human resources have not been fully resolved. The execution of GC6 implementation arrangements would have benefited from a structured capacity building plan to support the CMU and clarified agreements with the Government to align roles and responsibilities following the transfer of PR-ship to UNDP in 2021. These issues have hindered the impact of Global Fund grants and contributed to increases in HIV infections and AIDS-related deaths, poor quality of TB diagnosis, and high levels of drug-resistant TB missing

cases. An effective malaria response has been hindered due to delayed LLIN campaigns and inadequate epidemiological data.

Failure to fulfil Government co-financing requirements, and low utilization of available domestic funds are impacting progress against the three diseases

Pakistan did not meet its co-financing commitments and requirements for either GC5 or GC6 respectively. This resulted in the need to rationalize existing resources, slowed the roll-out of key TB prevention interventions, and limited the scale-up of critical HIV services and the overall effectiveness of disease response efforts. Key drivers for this include the under-absorption of allocated domestic funds, weak monitoring systems, and the sub-optimal application of co-financing policies by the Global Fund Secretariat.

Good availability of treatment commodities, but a fragmented approach to warehousing and distribution, and delays in local procurements, are affecting grant implementation.

While first-line TB and HIV treatment commodities were consistently available, the OIG noted stock-outs of specific diagnostic products. A fragmented approach to supply chain data systems, warehousing, and distribution, without appropriate mitigating oversight, has contributed to increased risks of stock-outs, expiries, and diversion of commodities, with some of these risks crystallizing and impacting program activities. Delays in local procurements and customs clearance further impact program effectiveness. Key drivers for these issues include a lack of national strategic governance and ownership over procurement and supply chain management, frequent senior staff turnover, and gaps in Global Fund Secretariat risk management.

Improved financial controls environment, but noncompliance with local procurement and recruitment policies was noted.

During GC6, US$74.8m has been budgeted for human resources costs.[4] Gaps in recruitment processes for sampled GC6-hired staff, and weak payroll controls such as non-adherence to recruitment practices and potential overpayments and duplicate payments to staff, undermine the significant investments made into human resources.

[4] Global Fund Data explorer, IG Data Explorer Pakistan, accessed on 17th December 2024.

1.4 Objectives, Ratings and Scope

Objectives	Rating	Scope
Grant governance, implementation arrangements and risk management to support the achievement of grant objectives for the three diseases.	**Ineffective**	**Audit period** January 2021 to December 2023.[5] **Grant and implementers** The audit covered the Principal Recipients and sub-recipients of Global Fund grants. **Scope exclusion** United Nations System organizations follow the "single audit principle", whereby they are subject to their internal oversight mechanisms at the exclusion of any other. The OIG cannot provide assurance on activities and transactions directly implemented by these agencies.
Procurement and supply chain processes and systems to ensure timely availability and accountability of commodities at all levels, with a focus on procurement and distribution.	**Needs significant improvement**	
Financial management controls relating to key cost categories.	**Partially effective**	

[5] The OIG also considered activities and transactions outside of the indicated dates based on the related risks and materiality of those activities and transactions.

2. Background and Context

2.1 Country Context

The Islamic Republic of Pakistan is a democratic federal state classified as a lower-middle-income country.[6] Since August 2020, it has been subject to the Global Fund's Additional Safeguard Policy (ASP), invoked to safeguard and enhance grants impact. This was in response to inadequate government commitment and capacity, ineffective oversight, challenges from devolution, ineffective implementation arrangements, and pending recoveries with insufficient commitment to reimburse.[7]

Pakistan is administratively divided into four provinces, two administrative territories, and one federal territory. Health planning, service delivery, and program implementation is devolved to the provincial level, and each province develops its own health policies.[8] At federal level, the Ministry of National Health Services, Regulations & Coordination (MoNHSRC) is responsible for national coordination, oversight of health sector regulatory bodies, enforcement of drugs laws and regulations, and coordination of all donor-funded preventive programs.[9]

Country data[10]	
Population (2024)	247.5 million
GDP per capita (2024)	US$1,407
Corruption Perception Index (2024)	134 of 180
UNDP Human Development Index (2024)	164 of 193
Government spending on health % of GDP (2024)	1%[11]

2.2 Global Fund Grants in Pakistan

Since 2003, the Global Fund has disbursed US$1.1 billion to Pakistan. GC6 grant budgets totaled US$439.1 million, of which 89% (US$389.5 million) had been disbursed as of November 2024.[12]

During GC6, dual-track financing (where both government and non-government actors serve as implementers) was maintained, to ensure that both public and non-governmental implementers were utilized to provide TB and malaria service components. Implementation arrangement for the TB grants followed this dual-track approach, with the public sector component managed by the National TB Program (NTP/CMU), and the private sector component managed by Mercy Corps, an international non-governmental organization. For malaria, the dual arrangement involved the public Principal Recipient (PR), Directorate of Malaria Control (DOMC/CMU), and the private PR, The Indus Hospital, continuing from the NFM2 implementation period. For HIV, UNDP was appointed as Principal Recipient by the Global Fund Secretariat under the Additional Safeguard Policy. The

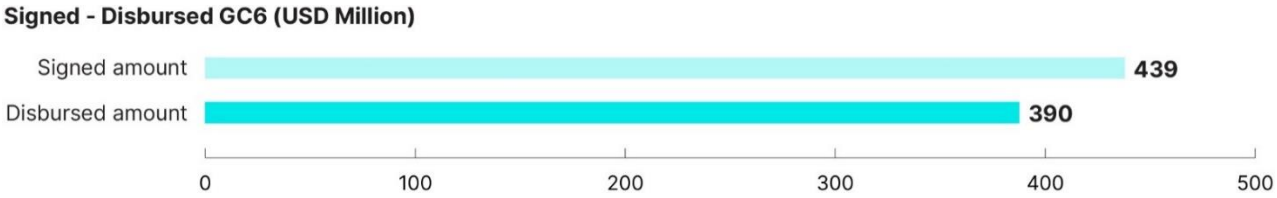
[6] World Bank Country and Lending Groups, World Bank Classification accessed on 25th November 2024
[7] ASP Invocation Memo, dated 27 July 2020
[8] WHO: Pakistan – Health policy, governance and leadership, WHO - Pakistan accessed 26 Nov. 2024
[9] As per the Ministry of National Health Services Regulation and Coordination, https://www.nhsrc.gov.pk/index accessed 27 Nov. 2024
[10] Sources: Global Health Workforce statistics database (WHO Data), GDP per capita (World Bank Group) Transparency International Report (Transparency International), UNDP 2023-2024 Human Development report accessed 26 Nov. 2024
[11] Pakistan Economic Survey 2023-24, Ministry of Finance-Government of Pakistan accessed 26 Nov. 2024
[12] The Global Fund's Data Explorer, Pakistan accessed on 26th November 2024

second HIV grant, which focused on people who inject drugs, was managed by Nai Zindagi Trust, a local NGO.

There have been several extensions and delayed starts to Global Fund grants. The GC5 TB grants were extended by six months into the GC6 period. The GC6 HIV grants were extended to December 2024, overlapping with the first year of the GC7 implementation period. The GC6 HIV grant extensions were due to iterations of the funding request, and the governance challenges outlined in finding 4.1 of this report.

In 2022, US$30 million in emergency funding was approved to ensure access to and distribution of essential medicines and health services, after flooding and landslides caused extensive damage to homes and infrastructure, including healthcare sites, and displaced millions of people.[13]

Figure 1: Funding allocation GC6 signed and disbursed amounts (as of November 2024)[14]



2.3 The three diseases

HIV / AIDS (2023)

290,000 people were living with HIV as of 2023, of whom 23% knew their status and 15% were on treatment.

Annual new infections increased by 64%, from 7,741 in 2018 to 12,731 in 2023.

AIDS-related deaths increased by 400%, from 2,200 in 2010 to 11,000 in 2023.

Only 11% of pregnant women who tested HIV positive received ARVs in 2023.

Source: UNAIDS Pakistan Country factsheet (UNAIDS Country factsheet) accessed on 26th November 2024 and Pakistan HIV MIS data

TUBERCULOSIS (2023)

TB disease burden in Pakistan is 6.3% of global TB incidence (5th highest rate worldwide) **Of the 686,000** estimated TB cases, 69% are notified.

Estimated TB incidence has remained constant since 2010, 276 per 100,000 people compared to 277 in 2023. However, in absolute numbers, **incidence has increased by 25%,** from 549,000 cases in 2010 to 686,000 cases in 2023.

Mortality rate has decreased by 7.5%, from 53,000 (2010) to 49,000 estimated number of deaths per year (2023).

Source: WHO Global TB report and country profile (WHO - Global TB Report 2024, WHO TB profile 2010-2023), accessed on 26th November 2024

MALARIA (2022)

Between 2021 and 2022, there was an increase of **2.1 million malaria cases.** WHO estimated **2.66 mil malaria cases** in 2022 (vs 505k in 2021). Fivefold increase in case incidence, **from 2.2 to 11.5 cases** per 1000 population at risk.

Estimated **malaria-related deaths** increased by 563%, from 460 in 2021 to 3049 in 2022, due to outbreaks following catastrophic flooding in 2022 that affected over 30 million people.

Source: WHO – World Malaria Report 2023 (WHO - World Malaria Report 2023) accessed on 26th November 2024

[13] The Global Fund website communications (Emergency Funding - September 2022 Emergency Funding - November 2022) accessed on 26th November 2024

[14] The Global Fund's Data Explorer, Pakistan accessed on 26th November 2024

3. Portfolio Risk and Performance Snapshot

3.1 Portfolio Performance

Global Fund grants[15] in Pakistan have relatively good programmatic performance and moderate financial performance against targets, as shown below[16] .

GC6 Allocation (2021-2023)	Grant Name	Start Date	End Date	PR Name	Approved Budget USD	Dec 2021		Jun 2022		Dec 2022		Jun 2023		Dec 2023	
HIV	PAK-H-NZT	2021-01-01	2024-12-31	Nai Zindagi Trust	31,114,433	B	1	C	2	C	2	A	2	A	2
	PAK-H-UNDP	2021-07-01	2024-12-31	United Nations Development Programme	57,065,711	C	5	C	5	C	5	C	5	C	2
Malaria	PAK-DOMC	2021-01-01	2023-12-31	Directorate of Malaria Control	58,320.091	B	4	B	2	B	1	C	1	C	1
	PAK-M-TIH	2021-01-01	2023-12-31	Indus Hospital & Health Network	24,354,568	B	5	A	5	A	3	A	5	C	2
TB	PAK-T-MC	2021-07-01	2023-12-31	Mercy Corps	33,215,700	C	5	C	4	C	4	C	4	C	2
	PAK-T-NTP	2021-07-01	2023-12-31	National TB Programme	235,013,692	C	5	C	5	C	5	C	3	C	3
Total					**439,084,195**										

3.2 Risk Appetite

The OIG compared the Secretariat's aggregated assessed risk levels in key categories covered in the audit objectives with the residual risk based on the OIG's assessment, mapping risks to specific audit findings. The full risk appetite methodology and explanations are detailed in Annex B.

Audit area	Risk category	Secretariat aggregated assessed risk level	Assessed residual risk based on audit results	Relevant audit issues
Governance	In-country governance	**Moderate**	**Very high**	4.1
Program quality	HIV: program quality	**Very high**	**Very high**	4.2
	TB: program quality	**High**	**High**	4.2
Procurement and supply chain management	Procurement	**Moderate**	**Moderate**	4.4
	In-country supply chain	**Moderate**	**High**	4.4
Health financing	Health financing	**Very high**	**Very high**	4.3
Internal controls	Grant-related Fraud & Fiduciary	**High**	**High**	4.5

[15] The approved amount for PAK-T-NTP includes funding for COVID-19 across all disease components and emergency funding is reflected under the malaria grants (30 mil USD).
[16] The budget amount of USD 439M includes USD102M related to C19RM. GC5 TB grants and GC6 HIV grants had extensions (which correspondingly used GC6 funding and GC7 funding),

4. Findings

4.1 Low Common Management Unit oversight capacity has limited impact of Global Fund grants

Limited capacity in the Common Management Unit (CMU) within the Ministry of National Health Services, Regulation, and Coordination (MoNHSRC) has led to a lack of national strategic direction, ownership and oversight. This has resulted in delayed program activity and persistent implementation issues across all three diseases.

Robust governance and adequate implementation arrangements are key enablers for programmatic impact, and ensuring grant objectives can be met. This is critical in a devolved context where provincial governments are responsible for health service delivery and program implementation. In Grant Cycle 6, several actions were implemented to strengthen governance and implementation, in response to previously identified issues. The Additional Safeguards Policy (ASP) was invoked in 2020 and resulted in UNDP replacing the Ministry of National Health Services, Regulations & Coordination (MoNHSRC) as a HIV Principal Recipient.

Dual track financing was continued, with international and local non-government organizations also supporting implementation. This ensures a range of expertise is leveraged, including from civil society and the private sector. Provincial governments became sub-recipients, to improve sub-national engagement. The Global Fund's Country Coordinating Mechanism (CCM) Evolution Strategic Initiative strengthened CCM policies and manuals, and improved CCM oversight. The Global Fund Secretariat also increased operational oversight over implementation.

However, ineffective oversight and accountability of the CMU have limited Global Fund grant impact:

Significant instability in the MoNHSRC has weakened CMU oversight and accountability, resulting in sub-optimal strategic direction and delayed implementation of key grant activities

The CMU is a program management unit within the MoNHSRC. Created in 2016, it is mainly funded by the Global Fund. Since GC5, US$16.7m[17] has been budgeted towards the CMU structure, along with associated government entities, to support 1,341 positions at federal and provincial level, including 255 management and administration federal-level roles. The CMU hosts the national HIV, TB and Malaria disease programs. It is charged with overseeing the work of the programs, setting the national strategic direction on the three diseases, and project managing the implementation of Global Fund-supported activities.

Despite the large investment in the CMU, it has not been able to effectively project manage global fund grants to support timely implementation, and did not fully establish the national strategic direction for all three diseases. Several key national policies and guidelines are either not approved or disseminated,[18] and there have been significant delays in completing key grant activities[19]. This is a repeat issue from the previous OIG audit in 2020.

This has hindered programmatic impact across all three diseases, and hampered efforts to respond to persistent programmatic issues and negative trends. There have been significant increases[20] in both new HIV infections and HIV-related deaths, and poor treatment cascade results. For TB, issues

[17] GC5 – USD 6.6M, GC6 – USD4.7M, GC7 (includes only TB and Malaria grants) – USD5.4M.
[18] a) 2023-26 HIV National Strategic Plan not yet approved. b) 2024 National TB treatment guidelines have been approved but not disseminated. c) No comprehensive national community health worker strategy covering key TB, HIV and malaria services, d) no operational plan for TB preventive treatment, and e) no government-approved supply chain strategies.
[19] Significant delays in the implementation of key activities, including Opioid Substitutional Therapy services, Integrated Biological and Behavioural Surveillance (IBBS) survey, TB prevention, and Long-Lasting Insecticidal Nets (LLIN) distribution.
[20] New infections rose by 64% (HIV program data) between 2018-23 & AIDS related deaths by 400% between 2010-23 (UNAIDS data).

persist with poor quality of TB diagnosis, a growing Drug Resistant (DR) TB treatment gap, and continually high levels of DR-TB missing cases (69%). This has led to a stagnation in TB incidences since 2010. The malaria response has also been hindered by poor LLIN distribution[21] and a lack of epidemiological data impacting grant design and relevance.

These issues in CMU effectiveness have been driven by several factors:

Weak performance management, oversight over the CMU, and project poor planning: The CMU has no key performance metrics to determine performance, and there is no evidence of any performance assessment of the structure having been conducted. The Global Fund does not have guidance on how to effectively design and oversee Program Management Units such as the CMU. There was no clear reporting line between the CMU and wider Ministry during GC6.[22] National programs have no approved annual work plans, objectives, or operational milestones to guide implementation.

Low CMU strategic and technical capacity: The strategic and technical capacity of the CMU has been negatively impacted by significant turnover in key CMU leadership positions. During GC6, a three-year period, the CMU national coordinator changed 10 times, the TB deputy national coordinator (DNC) five times, the HIV DNC four times, and the Malaria DNC three times. In addition, there have been protracted vacancies in key positions funded by the Global Fund, such as grant coordinator, TB advisor, Manager Procurement (MP) and chief procurement officer (CPO), which remained vacant throughout GC6. The current warehouse manager also holds the position of CPO and MP.

Instability in the MoNHSRC impacting oversight, accountability and capacity of the CMU: Significant turnover in MoNHSRC senior management has impacted how the CMU has been strategically managed. It has also allowed capacity issues within the CMU to persist. Since 2020, the Minister of the MoNHSRC has changed four times, and both the Secretary of Health and Director General six times.

Lack of clarity of roles and responsibilities between CMU and other government stakeholders: Although HIV grant implementation arrangements improved during GC6, issues noted in the previous OIG audit and other reviews have not been fully resolved.[23] These include weak CMU capacity, and unclear roles and responsibilities between government entities and UNDP. While UNDP conducted a capacity assessment for the national HIV program and provided training, a structured capacity-building plan with a baseline, targets and KPIs to track improvements was not developed. In addition, better clarity of roles and responsibilities in the new implementation arrangements between UNDP, the MoNHSRC and provincial governments is needed. While the Government was removed as PR under the HIV grant, they still had a key role in leading the HIV program response that needed to be reaffirmed. Inconsistencies in data sharing, co-financing requirements, and articulation of roles in GC6 grant agreements also impacted mutual understanding of responsibilities.

Gaps in Secretariat risk management: While the Secretariat attempted several initiatives to address some of the issues around governance and capacity, these were not successful in mitigating issues with CMU effectiveness. For GC6, the Secretariat did not develop mitigating actions in the Global Fund Integrated Risk Management Module (IRM)[24] to address the key risks raised in this finding. In GC7, the HIV grant includes an action to develop a technical assistance capacity plan for the national

[21] Per 2023 PU/DR only 47% and 56% of the target number of LLINs were distributed to at-risk populations by MoNHSRC and TIH.
[22] Post August 2024, a reporting line was set but without details on reporting required or monitoring and oversight expected over CMU.
[23] Previous OIG audit report issued in 2020, OIG_GF-20-012_report.pdf, accessed on 17th December 2024.
[24] The Integrated Risk Management Module (IRM) in the Grant Operating System is used by Country Teams to manage grant risks within their grant portfolio and is the primary tool used to gather and aggregate risk level information for the defined risks.

HIV program, but there is nothing similar for the TB or Malaria grants. While efforts have been made to modify the CMU structure to enhance its effectiveness, ultimately the need to strategically transform the CMU has not been meaningfully executed by the Secretariat as requested through the GC6 allocation letter and reaffirmed by the Technical Review Panel[25]. There is a need to better document and define the expected performance outcomes and value addition to be achieved from the CMU structure (in its current form), as well as how this would be routinely assessed.

Agreed Management Action 1

The Global Fund Secretariat will work with the Ministry of National Health Services Regulations and Coordination (MoNHSRC) to revise its governance arrangements to strengthen grant performance oversight. This will include providing:

a. clarity on the coordination mechanisms and roles and responsibilities, in particular vis a vis the different provinces, and
b. establishing Key Performance Indicators to drive and assess performance improvement of the CMU

These corrective measures will aim to address the gaps in project management, PSM, capacity building, delayed implementation, and gaps in coordination and delayed local procurements as identified in this audit. The Secretariat will assess the outcomes of the above corrective measures to further strengthen future governance arrangements.

OWNER: Head, Grant Management Division

DUE DATE: 31 December 2026

[25] The initial reform approach by the Secretariat, as codified in the GC6 allocation letter, was to strategically move away from reliance on a federal level CMU towards a provincial management approach. Retrospectively, this was deemed unfeasible by the Secretariat. However, no alternative way to strategically address CMU issues was proposed outside of adjustments to the CMU organogram.

4.2 Operational challenges have hindered impact of TB and HIV response

TB notifications have increased, and there is a high (95%) treatment success rate. However, high missing DR-TB cases, and low coverage of WHO-recommended diagnostics and TB preventive therapy, are resulting in stagnant TB incidence rates. There has been limited progress in HIV since the last OIG audit, with increasing new infections and deaths linked to poor domestic financing and weak national direction.

The Pakistan parliament declaration of TB as a notifiable disease supported a large increase in case notifications between 2020 and 2023, although there was still sub-optimal quality of diagnosis.[26] The proportion of case notifications from the private sector also increased, supported through the Mercy Corps grant.

For HIV, services to key population (KP) groups were expanded, a strong achievement in the context of widespread stigma and discrimination toward KPs and inadequate social protection. There was progress in Opioid Substitutional Therapy (OST), with drug regulatory approval obtained in 2023. Nai Zindagi, the NGO which manages the HIV grant focused on people who inject drugs, developed a strong beneficiary-centered approach, seeking continuous client feedback to improve services.

Large number of missing DR-TB cases, treatment gaps, and slow scale up of diagnostic and prevention interventions, despite significant funding from the Global Fund, have led to a stagnant TB incidence rate

The Global Fund invested US$165m in TB during GC6,[27] representing 49% of the total country allocation. There was an increase in use of WHO Recommended Diagnostics (WRDs) in absolute terms, but TB diagnosis quality targets were routinely missed. The use of WHO Recommended Diagnostics (WRDs) has not increased in line with Global Fund targets: 48% WRD diagnosis in 2023 versus a 75% target. Performance against DR-TB notification targets was also poor for MoNHSRC and Mercy Corps, at 45% and 38% for 2023. There was a DR-TB treatment gap of 22% in 2023, up from 12% in 2020. In addition, there was a delayed scale-up of TB prevention treatment (TPT), with 12% achievement of coverage targets in 2023.

These issues have contributed to sub-optimal quality of TB diagnosis (50% of TB notifications in 2023 were made through clinical diagnosis), persistent high levels of DR-TB missing cases (69%), large amounts of unused TB commodities (US$2.1m[28]) expiring during GC6, and low absorption of funds (for example 1% absorption of TPT budget under the MoNHSRC TB grant). This has hindered progress in reducing TB incidence and related deaths: TB incidence rates have been static since 2010, and TB-related deaths reduced at a slow rate of 9% from 2010 to 2023. These issues are linked to strategic governance and capacity challenges (see Finding 4.1) as well as operational challenges noted below:

Weak approach to using WRDs: Poor TB diagnosis is linked to low GeneXpert platform utilization (41% in 2023), an issue noted in the previous OIG audit. Low utilization is linked to inadequate sputum transportation coverage and oversight, and no monitoring of GeneXpert utilization.[29] There were also lapses in training, supervision and guidelines at TB sites, impacting demand generation for TB diagnostic services. Across nine TB sites visited by the OIG, none had TB guidelines, seven had no training materials, and five had no doctors trained in TB services. In addition, none of the sites had evidence of routine TB supportive supervisions. There were also issues in scaling up

[26] Global TB Report 2024 data for 2020 and 2023.
[27] The GC5 TB grants were extended by six months into the GC6 period.
[28] USD value is based on pricing units recorded in CMU records on expiries
[29] No systems or tools in place to monitor turnaround time (time between sputum samples being collected and results being received) and GeneX alert currently not functioning in country. However, the Mercy Corps GC7 grant aims to strengthen and scale-up sputum samples transportation in the country.

GeneXpert platforms, due to a 1.2-year delay in deploying 175 GeneXpert platforms (see Finding 4.4.).

No public-private approach: There is no national public-private mix strategy to improve private sector engagement and regulate their work in TB services. During GC6, the scale up of DR-TB sites was below target, with low absorption (57%) of available funds under the MoNHSRC TB grant.

Delayed and limited national guidelines: National prevention treatment guidelines were only approved in 2022. There is no operational plan for TPT, national community health worker strategy, or guidelines that cover TPT and active case finding (ACF). During GC6, community referrals and ACF targets have not been met, and there have been low budget absorption rates: 28% relating to lady health workers under the MoNHSRC TB grant, and 64% for ACF budgets under the Mercy Corps Grant.

Low and declining coverage of Key populations (KP), resulting in limited improvement of the overall trajectory of the HIV response.

HIV is concentrated in KP groups, with people who inject drugs (PWIDs) being the largest group, with a prevalence rate of 22%. However, there are limited services for KPs outside of Global Fund grants, leading to declining KP service coverage. There has been declining HIV testing and status awareness, a deteriorating conversion of KPs who are reached compared to those who are tested, and reduced treatment coverage of pregnant women (11% in 2023, compared to 17% in 2019).

This has contributed to low performance against the UNAIDS 95-95-95 targets: 23%-67%-76% in 2023, with limited progress since 2019.[30] There has been a 64% increase in new HIV infections since 2018, and a 400% increase in HIV-related deaths since 2010. Strategic drivers for the above are noted in finding 4.1, but further operational root causes are noted below:

Limited domestic financing for KP activities: At provincial level, there was no allocation of funds for KP activities in GC6, except for Punjab province, which budgeted for KP-related activities in 2024.

Lack of updated programmatic data on KP size estimates, risk profiles and epidemiology: The last Integrated Biological Behavioral Surveillance Survey (IBBS) was conducted in 2017. In GC6, US$3.5m was allocated for an IBBS to be conducted by December 2022, but this was not complete as of December 2024. This is due to the time taken by the MoNHSRC to approve, establish, and hold IBBS task force meetings, as well as other operational delays.[31] Progress is ongoing, and the IBBS is now due to be completed in the first half of 2025. As a result, the current design of HIV interventions targeting key populations remains limited.

Lack of national strategies and policies: As of November 2024, there is no approved minimum package of services to KP groups, no national operational guidelines tailored to KP groups, nor approved national guidelines for prevention of mother-to-child transmission of HIV (PMTCT). There are also no linkages between antenatal care sites (ANC) and PMTCT sites.[32] These factors have contributed to the low PMTCT indicator performance results in GC6, and the overall PMTCT response.[33] In addition, HIV data systems do not capture HIV data directly from ANC sites. Stock-outs of HIV test kits and condoms have also limited the availability of KP prevention services (see Finding 4.4).

[30] 95% of people living with HIV know their HIV status, 95% of people who know their status are receiving HIV treatment, and 95% of people on treatment are virally suppressed. UNAIDS data accessed on 2 Dec. 2024 - a 3% rise in the 1st 95 since 2019.
[31] Delays linked to revisions of terms of reference and delays in obtaining approvals from other government stakeholders.
[32] There are currently 14 PMTCT sites in the country.
[33] Percentage of HIV positive women who received ART during pregnancy and/or labour and delivery.

Agreed Management Action 2

The Global Fund Secretariat will work with the Ministry of National Health Services Regulations and Coordination (MoNHSRC) to:

a. Develop a MoNHSRC costed action plan to strengthen coverage and quality of sputum transportation, which leverages outcomes of this audit report and relevant third party led assessments already conducted; and
b. Secure the necessary endorsement of the National Public Private Mix Strategy to further enhance TB program notification

OWNER: Head, Grant Management Division

DUE DATE: 31 December 2026

No additional AMAs were proposed to address (a) delays in local procurement and delays and gaps in national guidelines as this is expected to be addressed through AMA 1, (b) limited HIV domestic financing and lack of national strategies and policies as this is expected to be partially addressed through AMA 1, though the Secretariat did not agree to an AMA to respond to co-financing issues raised in section 4.3 that also cover HIV domestic financing (c) lack of updated programmatic data due to the progress and near finalization of the National IBBS to inform program design.

4.3 Weak domestic health financing, due to non-utilization of available funds and poor co-financing oversight during GC6

Limited-quality health financing data, no monitoring by in-country stakeholders, and sub-optimal Global Fund implementation of the co-financing policy led to country co-financing requirements not being met for the last two implementation cycles.

Domestic financing for health should play a key role in tackling the three diseases in Pakistan. Significant funding gaps exist across the three diseases, with a limited number of external donors apart from the Global Fund. In this context, the need to incentivize and unlock additional domestic financing is critical to ensure the sustainability of disease responses, even in a lower-middle income environment.

The Global Fund Secretariat enhanced its approach to co-financing for Pakistan in the current grant cycle. In 2024, the first co-financing commitment letters were signed at the Federal level. Provincial-level commitment letters were also signed, a key enabler in the devolved context. Efforts are ongoing to improve the completeness of health financing data by leveraging the annual financial statements prepared by the Controller General of Accounts (CGA). Innovative financing arrangements have also been leveraged, with Global Fund grants supporting blended finance arrangements through a development bank.[34] The Global Fund Secretariat also conducted in-country missions in 2023-2024 to advocate for improved co-financing. However, lapses in utilizing available domestic financing, as well as weaknesses in the co-financing approach at both country and Global Fund Secretariat level, have resulted in limited co-financing increases since 2016.

Pakistan failed to meet its co-financing commitments[35] and requirements[36] for both GC5 and GC6.[37] For GC7, the co-financing requirement to increase domestic spending reduced compared to GC6, from 15% to 7.5%. Co-financing gaps have programmatic implications for the three diseases, as described in the previous findings. Limited financing has forced the rationalization of existing resources, and slowed the roll out of key interventions, e.g. for TB prevention activities. Limited financing has also impacted the scale up of key HIV services, with low coverage of key population groups and PMTCT services.

The persistent inability to meet co-financing requirements is driven by several factors:

Under-absorption of domestic financing at federal and provincial level: At federal level, absorption of available domestic funds allocated to HIV, TB and Malaria has been low: only 5% across the three diseases between 2022-25.[38] Similar under-absorption was also observed at provincial level. Punjab province has utilized only 64% of allocated HIV domestic funds between 2021-23, while utilization of allocated TB domestic funds in Khyber Pakhtunkhwa province has been just 9%. This low absorption results in decreases in subsequent government fund allocations to health.

Weak systems, tools and processes to effectively monitor and report on co-financing, and poor health financing data quality: There are no systems, tools or guidelines within the CMU to track and routinely report on co-financing achievement. Roles and responsibilities for this are unclear, between federal and provisional stakeholders. There is also a lack of consolidated data across all domestic

[34] In GC6, the Global Fund allocated US$5 million to a Multi-Donor Trust Fund to fund Pakistan's National Health Support Project. This led to the inclusion of a dedicated TB indicator as a disbursement led indicator in the loan performance framework.
[35] The Global Fund Secretariat communicated to Pakistan in the GC6 allocation letter that the overall expected domestic co-financing for 2017-2019 was US$144 million. Expenditures for GC5 were only US$116m, resulting in a shortfall of US$28m
[36] For GC6, Co-financing requirement 2: Demonstrating increasing co-financing to Global Fund supported programs over each allocation period. For Lower-LMICs such as Pakistan, co-financing contributions should be in line with identified priority areas within the programs or RSSH, with a minimum 50% of co-financing incentive in disease program interventions and 50% of the minimum additional for RSSH. As such, Pakistan was required to increase its total co-financing commitment to US$172m in GC6, using the expenditure reported in GC6 of US$116m as a base amount, and a minimum amount of additional co-financing investment of US$ 55.6m.
[37] Pakistan fell short of requirement 2 in GC6 by US$116m (US$$172m requirement vs expenditure of US$$56m).
[38] Total federal budget allocation of PKR 2BN between 2022-25, only 8% was spent in first year and 9% in second year. NB: 2024-2025 expenditure has been annualized based on Q1 2024 actuals (released budget: 15 mil, expenditure 5,454,162 PKR)

financing sources at both federal and provincial level. This is linked to the complex and fragmented approach to requesting, approving and disbursing of domestic financing, in line with devolution.[39] There has also been a lack of routine monitoring and oversight of co-financing progress by the Country Coordinating Mechanism (CCM). Co-financing tracking is not included in the routine CCM agenda, and co-financing was only discussed once at CCM level throughout GC6. In addition, the quality of health financing data provided to the Global Fund for GC6 has been poor, with completeness and accuracy issues.[40]

Sub-optimal application of the co-financing policy by the Global Fund Secretariat: There were material issues in the Secretariat's application of the Co-financing policy to the Pakistan portfolio during GC6. No GC6 commitment letter was signed either at federal level or provincial level. The GC6 baseline set by the Secretariat to assess co-financing achievement for the period was incorrect and was only identified as such by the Secretariat at the end of the grant period, limiting how it could be leveraged to hold country stakeholders to account.

Despite Pakistan being deemed non-compliant with co-financing requirements, the Secretariat waived the requirements during GC6, and did not apply a reduction in subsequent allocations. This waiver was granted based on economic/political factors, as well as the incorrect baseline that was developed, approved and communicated to the country by the Secretariat. This highlights an inconsistent approach to how different Global Fund policies are enforced, as an allocation reduction was enforced for unpaid recoveries.

The inability of the Global Fund to secure required co-financing, even given the economic and political challenges of the country, contrasts with successes by peer organizations operating in the same context, one of whose co-financing requirements for the equivalent GC6 period were met in full.[41]

No Agreed management action from the Secretariat on issues relating to sustainability, transition and co-financing.

The Global Fund Secretariat state they acknowledge the finding of the OIG audit and agree with the importance of advancing efforts on sustainability, transition, and co-financing in Pakistan. These are critical to support long term sustainability of the national HIV, TB, and Malaria responses and to support gradual transition away from Global Fund financing.

The Secretariat has committed to support the country with a sustainability and transition analysis that will help define transition pathways for Global Fund funded activities, as well as inform co-financing requirements and grant design in GC8 however does not want to formalize this into an agreed management action.

[39] There are also parallel processes to obtain domestic financing through both development projects and recurring spending and inconsistencies across provinces in how domestic financing is approved and allocated.
[40] Country provided expenditure data for GC6 domestic financing for USD 109.8m, however the Global Fund Secretariat noted errors in the computation resulting in a reduction in domestic funding from $109.8M to $53.2M.
[41] The peer organization approaches co-financing differently through requiring direct and simultaneous purchase of commodities to the same procurement agency.

4.4 Treatment commodities are available, but sub-optimal PSM ownership has delayed grant activities and led to product diversion, expiries, and reduced value for money

A fragmented approach to warehousing, distribution and Procurement and Supply Chain Management (PSM) systems hinders visibility of commodities at sub-national level, and increases risks of stock-outs, expiries and diversion. Local procurement delays also adversely affect implementation of key grant activities.

PSM-related costs[42] represent 59% of the GC6 budget, highlighting the importance of robust PSM systems, tools and processes. Continuous availability of first-line TB and HIV treatment commodities was observed at all sites visited, though stock-outs were noted for specific diagnostic products. The Global Fund's Pooled Procurement Mechanism (PPM) and Global Drug Facility have been used for international procurements to mitigate several procurement-related risks. Procurement and inventory management manuals and procedures were updated in 2022, to support better PSM processes.

Lack of warehousing management systems, and sub-optimal warehousing and distribution, increase the risk of stock-outs and limit product traceability

The PSM system landscape is fragmented. There is no agreed electronic logistical management information system (LMIS) or warehouse management information system (WMIS) at federal or sub-national level. This has resulted in multiple systems being used, and a reliance on Microsoft Excel and manual tools to record and report key PSM data. This leads to poor-quality supply chain data to track commodities and monitor consumption and stock levels. The WMIS at the Central Medical Store (CMS) warehouse is not fully functioning: there are no controls to prevent duplicate ordering entries, and the reporting module is not configured to remove expired commodities from stock reports or record returns of expired products from the sub-national level.[43] The CMS relies instead on Excel and manual ledgers to manage inventory, which leads to data gaps.[44]

Warehousing and distribution are fragmented and sub-optimal. No warehouse rationalization, optimization planning, or warehousing reviews have been conducted to date. Currently, a blend of rented warehouses, government warehouses, and office spaces are used to house Global Fund commodities. The contracting and use of warehouse spaces is decentralized, managed by national program staff without oversight or regular monitoring from the CMU PSM team or other PSM technical group. There is no established reporting line between rented warehouses and the CMS warehouse manager, meaning rented warehouse sites are not routinely supervised by CMS staff.[45] Provincial authorities are not consistently aware of commodities entering and leaving their regions, further reducing oversight.

Fragmented PSM systems, warehousing and distribution without compensating oversight and monitoring led to several material issues. Ineffective warehouse management controls led to expired HIV test kits being distributed from CMS to provincial level.[46] Limited visibility on consumption and stock level data contributed to TB and HIV commodities worth US$0.8m expiring at sub-national level, and condoms and HIV test kits stock-outs at 27% and 64% of visited sites.[47] These stock-outs affected prevention activities and HIV testing, as mentioned in Finding 4.2. Limited commodity traceability led to approximately 369,000 LLINs worth US$0.9m becoming unaccounted for during 2024. Inefficient storage and distribution also drove up costs, impacting value for money. For

[42] This includes budgeted costs of health and non-health related commodities and PSM costs.
[43] The Central Warehouse WMIS is IDMIS. Support for IDMIS was provided by Chemonics but this ended in April 2024.
[44] IDMIS recorded expires in GC6 of USD1m compared to manual records that recorded USD3.3m.
[45] Two rented warehouses are used in KP and Baluchistan province for LLIN storage. External assurance provider reports highlighted lapses in CMU supervision and security controls at these warehouses. These warehouses report directly to the disease program managers in CMU.
[46] 43,200 Expired Determine Kits were issued from the CMS warehouse to Khyber Pakhtunkhwa in April 2023.
[47] Stock outs for condoms were at 3/11 sites (all supported by govt); HIV kit stock outs were noted at 7/11/ sites (3 supported by govt and 4 of 5 CBOs supported by UNDP): for between 5 to 119 days for Determine kits and 30 to 60 to 198 days for Unigold kits.

example, transporting LLINs from port in the Sindh province to rented warehouses in other provinces, only to return subsequently to Sindh, led to an unnecessary distribution cost of US$0.2m.

CMU local procurements have been significantly delayed, affecting implementation of program activities and risking product quality

US$4.3m of CMU local procurements undertaken in GC6 were delayed for an average of 668 days as of November 2024 and were still not completed at the time of the audit. This includes the procurement of CMS warehouse equipment[48] (on-going for 1,003 days), GeneXpert auxiliary equipment (601 days), and third-party logistics services (438 days). These procurement delays have knock-on implications that affect much larger investments in grants.

Consequently, 175 GeneXpert platforms remained in storage for over 1.2 years, with a missed opportunity to conduct potentially 0.5 million additional tests in this period. This limited the scale up of TB notifications through WHO-recommended diagnostics. Delays in purchasing the necessary equipment at the CMS warehouse reduced its functional space to a third of its planned capacity, resulting in haphazard storage of products. This has impacted effective inventory management and increased product quality risks, due to the lack of a system to monitor and maintain consistent temperatures. In 2024, recorded temperatures exceeded 38 degrees, potentially impacting heat-sensitive items[49]. Isolated customs clearance delays for LLINs and GeneXpert cartridges delayed the LLIN distribution, and cost US$0.6m in demurrage and storage fees.

The above PSM system, warehouse, and local procurement challenges stem from:

Lack of national strategic governance, ownership and technical oversight over key PSM operations: There are no national or provincial Supply Chain strategies or strengthening plans to provide strategic direction to tackling supply chain issues. There are also undefined roles and responsibilities over PSM technical areas among different government stakeholders at federal and provincial level, limiting accountability over supply chain issues in the devolved context. There are no technical working groups that focus on supply chain matters, despite many of these issues being identified as required in prior PSM assessments.

Significant gaps and turnover in senior PSM positions at federal level: Within MoNHSRC, a procurement cell was established in April 2023 and disbanded six months later. There have also been vacancies and changes in CMU staffing for key PSM-related positions (see Finding 4.1), which slows PSM progress and limits segregation of duties in procurement approvals. This led to key PSM operational activities not being performed during 2021-23, and persistent gaps in appropriate PSM systems, tools and processes in the CMU.[50]

Gaps in Global Fund Secretariat risk management: The lack of government strategies, policies and technical working groups for supply chain were not identified as risks in the Global Fund Integrated Risk Management Module (IRM) for either GC6 or GC7 by the Secretariat. Thus, no mitigating actions were developed for these areas in the IRM. Risks relating to LMIS, local procurements, warehousing and distribution were identified by the Secretariat in the IRM, but not yet fully mitigated, as some mitigation activities are still ongoing. An LMIS strengthening plan was created as a GC6 mitigating action but was not completed and was rolled over to GC7. LMIS assessments that were due to be conducted by a Secretariat monitoring provider in GC6 were also delayed due to capacity constraints. No mitigating actions were developed by the Secretariat in GC6 to tackle issues around warehousing, distribution and local procurement. Mitigating actions have been developed for GC7, however they do not fully address all the issues identified above.[51]

[48] This includes warehouse racking as well as heating, ventilation and air conditioning (HVAC) systems.
[49] Includes HIV test kits and GeneXpert TB cartridges.
[50] This includes the development of annual local procurement plans that were not completed for 2021-23 and not yet finalized for 2024. In addition, it allowed the lack of systems, tools and processes to track and monitor local procurement timelines end-to-end to persist.
[51] For distribution, there is a GC7 planned assessment of distribution within provinces that is expected in 2025. For Local Procurement, increased oversight by the Global Fund has been in place since 2022 and a mitigating action to strengthen oversight of local procurements by Secretariat Monitoring Providers is in place for GC7. However, these actions do not tackle significant delays in completing procurements, although they have partially mitigated the risk.

No additional AMAs were proposed to address the lack of national strategic governance, ownership and technical oversight and significant gaps and turnover in senior PSM positions as these are expected to be addressed through AMA 1.

4.5 Strong financial controls, but procurement non-compliances and non-competitive recruitment practices have persisted

Principal Recipients (PRs) have developed policies and manuals for financial management, procurement and recruitment. However, policy non-compliance has resulted in increased risks of non-competitive and biased recruitments, and poorly executed local procurements.

Financial expenditure, local procurement compliance, and recruitment and payroll processes were reviewed for all PRs except UNDP.[52] Financial controls have been strengthened since the last OIG audit in 2020. Electronic financial management systems are in place at all PRs, as well as approved finance manuals. Segregation of duties is embedded in controls over processing and paying activity-related expenditures. Financial control environment assessments supported by the Global Fund led to actions to strengthen controls. As a result, no material unsupported expenditure was identified in sampled transactions for Mercy Corps (MC), Nai Zindagi (NZT) and the Indus Hospital (TIH), but there were moderate issues for the CMU grants.[53] The Global Fund Secretariat has increased its oversight over local procurements since 2022.[54] MC and NZT developed preferred supplier listings to support local procurement, and MC uses an end-to-end procurement system to mitigate procurement evaluation and contract management risks. For human resource (HR) management, manuals were updated for all PRs, and salary payments were made using bank transfers to reduce fraud risk.

Non-adherence to proper recruitment practices and gaps in payroll management undermine the effectiveness of HRH investments and value for money in salary payments.

Across all PRs in GC6, 5,214 positions were funded at federal and sub-national level. The Global Fund budget for HR costs was US$40.8m in GC6 and US$52.6m for GC7.[55] Hiring staff do not consistently follow proper recruitment and due-diligence processes. For recruitments sampled across all PRs (excluding UNDP), 22% were not publicly advertised, 29% were not subject to a shortlisting process, and 19% did not include an interview stage. 62% of recruited staff did not have prior employment references checked, and none had their qualifications reviewed.[56] Exceptions were noted across all grants, increasing the risk of biased recruitment and the hiring of candidates that are not the best available in the open market.

The main driver for poor HR controls is a lack of guidelines or non-adherence to existing guidelines, combined with the absence of an end-to-end electronic HR system to support recruitment and payroll across implementers.[57] In addition, there are gaps in HR manuals for how references and qualifications are reviewed.[58] At the CMU, while the HR manual requires a Fraud Risk Management Committee (FRMC) to be established, this is not in place. The CMU's Internal Audit function raised HR control issues, but there is no Audit Committee or similar governance oversight body to ensure effective action.

Payroll control weaknesses for Global Fund-supported staff in the CMU were also observed. The CMU failed to reconcile work attendance data with payroll records. As a result, employees were

[52] UN System organizations follow the “single audit principle”, whereby they are subject to their internal oversight mechanisms at the exclusion of any other. The OIG cannot provide assurance on activities and transactions directly implemented by these agencies.
[53] For CMU grants, 12% (US$43k) of sampled transactions US$43k were unsupported. They primarily relate to unretired advances dating back to 2012. They were caused by weak advance management systems, tools and processes. The CMU Financial Management System does not have an advances module and cannot run advances aging analysis, and no Microsoft Excel/manual tools have been developed to track advances to mitigate these system limitations.
[54] The Global Fund Secretariat reviews local procurement plans for each PR, reviews all procurement documentation before contracts are awarded and uses external monitoring providers to review all open tender bid documentation to ensure compliance.
[55] GC6 excludes UNDP human resources costs and GC7 includes only TB and Malaria related grants, as HIV grants for GC7 were not signed at the time of the audit fieldwork (November 2024).
[56] From 2024, Indus Hospital and Health Network engaged a third-party to verify the academic qualifications of the PR employees.
[57] At CMU and TIH, applications and longlisting are conducted through their HR systems, but the other stages e.g. shortlisting candidates are completed manually. At NZT and MC the entire recruitment process is processed manually outside of a HR system.
[58] Nai Zindagi and CMU HR Manuals do not articulate the process of conducting due diligence checks and the HR manuals at Mercy Corps, Nai Zindagi, and CMU lack guidelines on how reference checks are to be performed.

potentially paid 898 days more than expected, based on the biometric attendance register during GC6. There were also instances where CMU staff, paid full time by the Global Fund, received payments from other sources concurrently.[59] Data from the CMU biometric attendance system to account for staff attendance was not leveraged to calculate employee pay. These issues were identified in prior Secretariat-led reviews in 2023 but had not been sufficiently addressed at the time of the OIG audit in October 2024.

Inconsistent procurement thresholds, and lapses in following approved local procurement policies, increase fraud and fiduciary risks, and reduce value for money for grants.

The CMU, despite being a government department within the MNHSRC, does not adhere to national thresholds for local procurements.[60] A threshold of PKR3m (US$10.8k) is used for Global Fund-supported local procurements to determine when open competition is needed, which is six times higher than the national threshold. The CMU PR local procurement manual also inconsistently references both thresholds. This lack of alignment and inconsistent guidance makes it unclear if local procurements are compliant: using the Public Procurement Regulatory Authority (PPRA) of Pakistan threshold, 20% of sampled local procurements did not follow the correct procurement process, but using the CMU specific threshold, only 2% were non-compliant. Not adhering to national regulations undermines sustainability and increases the use of restrictive tendering that can reduce value for money. These issues were flagged in the previous OIG audit and in Global Fund Secretariat-led reviews driven by gaps in CMU capacity (as mentioned in Finding 4.1). Secretariat oversight and monitoring has not been effective in resolving this issue.

Non-compliant local procurement practices were noted under the Nai Zindagi grant, relating to two isolated but material GC6 procurements worth US$3.7m. This refers to the direct sourcing of auto-syringes in GC6 without appropriate justification,[61] and the procurement of living support provisions between 2019 and 2023, using limited/restrictive tendering without appropriate justification.[62] These exceptions were previously highlighted in the 2020 OIG audit. Non-competitive procurements result in a potential value for money loss.[63]

These non-compliant instances were caused by the NZT procurement manual not defining how user preference of syringes is factored into procurement decisions. In addition, there is no structured approach on how and when user preference feedback is sought, and no Global Fund guidance for this. Secretariat oversight was not effective in ensuring these procurement issues were dealt with in a timely manner. The Secretariat raised similar points about the lack of market surveys and open tendering, but approvals to proceed were still provided. In 2024, NZT addressed non-competitive procurements, and ensured that subsequent procurement processes for both syringes and living support provisions are aligned with procurement policies.[64]

[59] Additional payments of US$0.1m were observed. The OIG cannot provide assurance that there are no other instances due to lack of available data. The Global Fund secretariat issued a demand letter for US$0.053m to the CMU on 8 October 2024.
[60] These are set by the public procurement regulatory authority (PPRA) and adhered to by government entities.
[61] No comprehensive user preference survey comparing auto-syringe brands was conducted to justify single sourcing.
[62] No market survey/analysis conducted to support restrictive procurement practices. Based on GF Secretariat approvals procurement of living support provisions was singled sourced from a government supplier between 2018-19 with no documented market survey analysis. Restrictive tendering (request for quotations – RFQs) was used between 2019-23 with no documented market survey analysis. Per the PR local procurement manuals, open competitive tendering was required in all cases.
[63] Based on comprehensive user preference brand comparison surveys conducted in 2024, a more cost-effective supplier of syringes was contracted. Using 2024 supplier pricing and applying this to prior procurements indicates a potential value for money loss of USD 0.1m. No value for money analysis could be conducted for living support provisions due to lack of comparable data to compare pricing.
[64] Comprehensive user preference brand comparison surveys were conducted in Jan and July 2024 to support the single sourcing of a new syringe supplier. An open tender procurement process was conducted in June 2024 to identify a new supplier of living support provisions from June 2024 onwards.

Declining management action on non-adherence to proper recruitment practices and gaps in payroll management

The Global Fund Secretariat did not agree with the OIG proposal to (a) conduct an independent review of staff currently funded by the Global Fund to determine where applicable HR recruitment policies have not been followed and apply corrective action and (b) ensure all new HR contracts and contract extensions follow appropriate applicable HR policies through implementing an additional independent review step.

The Global Fund Secretariat state that they are actively responding to the issues identified in this finding relating to recruitment practices and payroll management through its implementation of the Fraud Risk Assessment (FRA) recommendations (2023), adherence to Technical Review Panel (TRP) GC7 recommendations, and Local Fund Agent (LFA) supervision of key HR processes. An additional layer of oversight, Key Mitigating Actions have been adopted to expedite the necessary corrective measures being applied through the course of GC7.

Declining management action on gaps in the procurement approach for syringes and process to seek user preference feedback on these commodities

The Global Fund Secretariat did not agree with the OIG proposal to work with NZT to (a) develop a PR level framework to determine the approach to seek user preference feedback on commodities and health products, and (b) update relevant PR procurement manuals to clarify how user preference results are used in procurement decisions.

The Global Fund Secretariat state that as part of its existing processes they will conduct user preference studies as circumstances and programmatic indicators deem necessary, in alignment with best practices available in the harm reduction space, and WHO recommendations as applicable.

Annex A. Audit rating classification and methodology

Effective	No issues or few minor issues noted. Internal controls, governance and risk management processes are adequately designed, consistently well implemented, and effective to provide reasonable assurance that the objectives will be met.
Partially Effective	Moderate issues noted. Internal controls, governance and risk management practices are adequately designed, generally well implemented, but one or a limited number of issues were identified that may present a moderate risk to the achievement of the objectives.
Need significant improvement	One or few significant issues noted. Internal controls, governance and risk management practices have some weaknesses in design or operating effectiveness such that, until they are addressed, there is not yet a reasonable assurance that the objectives are likely to be met.
Ineffective	Multiple significant and/or (a) material issue(s) noted. Internal controls, governance and risk management processes are not adequately designed and/or are not generally effective. The nature of these issues is such that the achievement of objectives is seriously compromised.

The OIG audits in accordance with the Global Institute of Internal Auditors' definition of internal auditing, international standards for the professional practice of internal auditing and code of ethics. These standards help ensure the quality and professionalism of the OIG's work. The principles and details of the OIG's audit approach are described in its Charter, Audit Manual, Code of Conduct and specific terms of reference for each engagement. These documents help safeguard the independence of the OIG's auditors and the integrity of its work.

The scope of OIG audits may be specific or broad, depending on the context, and covers risk management, governance and internal controls. Audits test and evaluate supervisory and control systems to determine whether risk is managed appropriately. Detailed testing is used to provide specific assessments of these different areas. Other sources of evidence, such as the work of other auditors/assurance providers, are also used to support the conclusions.

OIG audits typically involve an examination of programs, operations, management systems and procedures of bodies and institutions that manage Global Fund funds, to assess whether they are achieving economy, efficiency and effectiveness in the use of those resources. They may include a review of inputs (financial, human, material, organizational or regulatory means needed for the implementation of the program), outputs (deliverables of the program), results (immediate effects of the program on beneficiaries) and impacts (long-term changes in society that are attributable to Global Fund support).

Audits cover a wide range of topics with a particular focus on issues related to the Impact of Global Fund investments, procurement and supply chain management, change management, and key financial and fiduciary controls.

Annex B. Risk appetite and risk ratings

In 2023, the Global Fund operationalized a new Operational Policy Note (OPN), setting recommended risk appetite levels for 13 key risks affecting Global Fund grants, formed by aggregating 35 sub-risks. Each sub-risk is rated for each grant in a country, using a standardized set of root causes and combining likelihood and severity scores to rate the risk as Very High, High, Moderate, or Low. The sub-risks rating is aggregated at risk level and then individual grant risk ratings are weighted by the grant signed amounts to yield an aggregate Residual Risk Level (current risk level) for a country portfolio. A cut-off methodology on high risks is applied (the riskiest 50% of grants are selected) to arrive at a country risk rating.

OIG incorporates risk appetite considerations into its assurance model. Key audit objectives are generally calibrated at broad grant or program levels, but OIG ratings also consider the extent to which individual risks are being effectively assessed and mitigated.

The OIG's assessed residual risks are compared to the Secretariat's aggregated risk levels for the 13 country-facing risks which fall within the audit's scope. A narrative explanation is provided every time the OIG and the Secretariat's risk ratings differ. Additionally, for risk categories where the organization has not set formal risk appetite or levels, the OIG can opine on the design and effectiveness of the Secretariat's overall processes for assessing and managing those risks.

Global Fund grants in Pakistan: comparison of OIG and Secretariat risk levels

Overall, the updated Secretariat risk levels assessment (December 2024) is aligned with the OIG audit rating except in two key risk areas: Governance and In-Country Supply Chain.

The ***In-country governance risk*** is composite of the following sub-risks, (i) Health Sector Governance, (ii) National Program governance, (iii) PR Governance, (iv) Implementation effectiveness and (v) CCM governance. The OIG and the Secretariat have similar levels of assessed risk for (ii) and (v) but different levels of assessed risks related to (i), (iii) and (iv) rated as “moderate” by the secretariat and “very high” by OIG. This is because of lack of national strategic direction, ownership and oversight over the three diseases as well as limited capacity and significant turnover in the CMU and MoNHSRC which have resulted in delayed program activity and persistent implementation issues hindering the HIV, TB and Malaria response. There has been significant turnover in key MoNHSRC senior management positions which severely impacts the monitoring and oversight of the CMU.

In-Country Supply Chain risk is a composite of several sub-risks, including: (i) Health Product warehousing, (ii) Health Product distribution, (iii) Health Product information systems. The OIG and the Secretariat have similar levels of assessed risk for (iii), but different levels of assessed risks related to (i), and (ii) rated as “moderate” by the secretariat and “high” by OIG. This is due to several issues highlighted in the report in finding 4.4. These issues increase the risks of stockouts, expiries, limited traceability, poor quality and sub-optimal value for money for Global Fund commodities.

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